

MONTANA SAFETY ASSESSMENT AND MANAGEMENT SYSTEM

Protection Plan

REPORT NAME:	DATE OF REPORT:	DATE OF INITIAL CONTACT W/TARGET CHILD:
REPORT NUMBER:	CHILD PROTECTION SPECIALIST NAME:	

Identification and Description of Immediate Danger Threats: Describe the identified safety threats that are actively occurring or in process of occurring and will likely result in actual or substantial risk of physical or psychological harm to a child. Clearly describe how the child(ren) has experienced actual harm or is at substantial risk of experiencing harm justifying the use of a Protection Plan.

<p><i>Purpose: To describe the identified safety threats that are placing the child at actual or substantial risk of harm and justifying the use of a Protection Plan.</i></p>
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- ☐ ICWA – Does not apply
- ☐ ICWA – Please indicate how the child qualifies under ICWA
- ☐ Birth Mother Tribal Affiliation _____
- ☐ Birth Father Tribal Affiliation _____

All voluntary placement agreements must be recorded before a Judge in a court of competent jurisdiction and accompanied by the Judge's certificate that the terms and consequences of the consent were fully explained in detail and were fully understood by the parent or Indian custodian.

ICWA placement preferences also apply to voluntary foster care placement.

JUSTIFICATION OF CAREGIVER(S) AGREEMENT AND WILLINGNESS TO PARTICIPATE IN THE DEVELOPMENT AND UTILIZATION OF THE PROTECTION PLAN: Describe efforts made to engage each Caregiver in the development of the protection plan and their level of commitment to ensuring the plan is utilized as developed. If the Caregiver(s) is/are unavailable to participate please explain why.

Purpose: To ensure family engagement efforts and to document the parents' response to family engagement efforts. Family developed plans lend to buy in and success as well as more least restrictive placement opportunities for kids. If a Kinship placement was not utilized explain why.

IDENTIFY THE PROTECTIVE PERSON(S) RESPONSIBLE FOR PERFORMING THE SAFETY ACTIONS, TASKS, OR SERVICES NECESSARY IN CONTROLLING FOR SAFETY THROUGHOUT THE USE OF THE PROTECTION PLAN: Describe how protective adults participating in the Protection Plan were confirmed to be suitable, appropriate, possess sufficient protective capacities, and are aligned and in agreement with CFSD. Clearly justify the protective person(s) availability, and ability to be reliable and trustworthy. Describe in detail the protective actions, tasks, or services selected to control for safety and how those actions will control for all identified safety threats.

Purpose: To ensure that the resources being utilized are safe and appropriate, clearly understand their role and are reliable in performing it. Justification that the persons identified as safe can actually aide in controlling for safety.

DESCRIBE THE PLAN FOR VISITATION BETWEEN CAREGIVER(S) AND CHILD(REN):
Describe in detail the initial visitation plan between caregivers and children. The visitation plan should be specific to each caregiver. *If a visitation plan cannot be established please explain why.*

The date and time of the initial visit is: _____.

The visit(s) will take place at: _____.
(Location/Address)

The visit will be planned for _____ hours.

Visit start time: _____ Visit end time: _____.

Visitation will be supervised? Yes or No
(circle one)

If Yes, Who is responsible for supervision? _____

Purpose: "To Be Determined" or N/A is not a suitable answer, a visitation plan should be developed and articulated even if it is only a temporary plan and/or only encompasses the initial interaction. A visitation plan should be articulated even when utilizing an in-home protection plan or placement with a non-custodial parent. Describe WHO will be facilitating or supervising (if applicable) the visitation between child(ren) and caregiver(s), WHEN the visit will occur, WHERE the visits will be held, HOW often the visits will occur, and WHAT arrangements are necessary for transportation to and from the visitation location.

DESCRIBE THE ANTICIPATED TIME FRAMES FOR WHICH THE PROTECTION PLAN WILL BE ACTIVE AND HOW CFSD WILL PROVIDE FOR MONITORING AND OVERSIGHT:

Describe the Child Protection Specialist's plan for interacting with the caregiver(s), child(ren), and safety resource providers throughout the use of the Protection Plan. **Noting that supervisory oversight will occur weekly while the Protection Plan is active.*

This Protection Plan begins on _____, and will end on _____.
(date)

(date)

The Child Protection Specialist's plan for interaction with each caregiver is: _____.

(frequency)

The Child Protection Specialist's plan for interaction with each safety resource is: _____.
(frequency)

The Child Protection Specialist's plan for interaction with each child is: _____.
(frequency)

Purpose: To ensure that the plan is being actively monitored in effort of continually assessing for safety and in evaluation of the safety resources and their ability to effectively and dependably control for safety. Describe WHEN, WHERE, and HOW, these interactions will occur.

(If an out of home plan is utilized- plan may not be in place more than 30 days. If an in-home plan is utilized- plan may not be in place more than 60 days.)

OUT OF HOME PLAN:

☐ Part A: Placement with Non-Custodial Parent

Under the terms of this agreement, the undersigned agrees to provide care to the following children:

- 1) _____
- 2) _____
- 3) _____

The undersigned attests that:

- 1) My parental rights to the above-named child(ren) remain intact and that no court of competent jurisdiction has terminated the parent-child legal relationship between me and my child(ren).
- 2) I understand that the initial plan for my child(ren) will be reunification with the parent from whom, because of child safety issues, the child(ren) were removed.
- 3) I understand that the permanent plan for my child(ren) is the following:

_____ reunification with the children's custodial parent. If this is the plan for my children, I will cooperate with my child(ren)'s social worker to effectuate this plan.

_____ no reunification with the children's custodial parent. If this is the plan for my children, I will pursue obtaining custody of my children so the child abuse and neglect proceeding involving my children may be dismissed.
- 4) I understand that my child(ren)'s social worker will conduct a search to determine if I have a child protective services history which poses a risk to my child(ren).
- 5) I have not been convicted (within the last five years) of a felony which indicates that placement in my home poses a risk to my child(ren). A felony conviction which poses a risk to my child(ren) includes, but is not limited to, a conviction for:
 - a) child abuse or neglect;
 - b) spousal abuse;
 - c) crimes against children (including child pornography);
 - d) crime involving violence; or
 - e) drug-related offense.
- 6) If I do not reside in the State of Montana, I understand that my child(ren)'s social worker must comply with the requirements of the Interstate Compact on the Placement of Children, MCA § 41-4-101 et seq.

Please attach Form CFS-032 to the back of this form for additional Non-Custodial Placements.

☐ Part B: Placement with Kinship Care Provider

This agreement is between the Montana Department of Public Health and Human Services, hereinafter referred to as the "Department," and _____ regarding the
name of kinship provider(s)
temporary care of _____
name(s) of child(ren)

The Department will be conducting both a criminal records check and a child protective services check on all adults living in the household. If you have been convicted of a crime in the past, are currently charged with a crime, or have been investigated for child abuse or neglect, TELL THE CHILD PROTECTION SPECIALIST IMMEDIATELY.

Have you or anyone living in your household been charged or convicted of:

	Felony		Misdemeanor	
Child abuse, neglect or endangerment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Partner or family member assault	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any crime against children including child pornography	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A crime involving violence, including rape sexual assault or homicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A crime involving serious harm to children.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical assault	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Battery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A drug related offense, including an alcohol related conviction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you or anyone in your household been the subject of a deferred prosecution or a deferred imposition of sentencing involving one or more of the crimes listed above? ☐ Yes ☐ No

Have you or any person living in your household been investigated for alleged child abuse or neglect? ☐ Yes ☐ No

Have you or anyone in your household had a substantiated allegation of child abuse or neglect? ☐ Yes ☐ No

Are you or anyone in your household suffering from a debilitating medical condition for which medical marijuana is being used in compliance with Montana law? ☐ Yes ☐ No

Explain any 'Yes' answer below:

Provide the names of everyone living in your household:

Fingerprint based criminal records checks are required for all adults in a kinship provider's household. Completed fingerprint cards must be returned by _____ (within 3 business days of receipt). To arrange to be fingerprinted, contact:

FOR EMERGENCY BACKGROUND CHECK ONLY

*Pursuant to 41-3-304 MCA; if adult refuses consent to the Department's request for a Federal name base and Fingerprint based criminal background check the Department may not place the child in the home in which the adult resides or if the child was already placed in the home, the Department shall immediately remove the child from that home. Per 41-3-304 MCA; If the Department elects to perform an initial name based background check and a fingerprint-based background check pursuant to this section, the Department may not make an emergency placement or continue an emergency placement in a home in which an adult resident has been convicted of a disqualifying criminal offense.

Kinship Provider Signature _____ Date _____ Kinship Provider Signature _____ Date _____
I have received the IMPORTANT INFORMATION ABOUT KINSHIP CARE & KINSHIP PROVIDER RESPONSIBILITIES handout

Kinship Provider Initials _____ Kinship Provider Initials _____

Please attach Form CFS-055 for additional Kinship Placements to the back of this form.

☐ **Part C: Voluntary Placement with Foster Parents**

This agreement is between _____, mother/father/legal custodian of
_____ and the Montana Department of
Public Health and Human Services, hereinafter referred to as the "Department".

Parent's Agreement

1. I, _____, hereby request the Department to place my child/ren in foster
care from _____ to _____.
2. The pertinent information regarding the child/ren follow: _____

I agree that the Department may secure routine medical and dental care as advised by physicians or dentists. I understand that the Department will notify me whenever possible in case of hospitalization or surgery. In the event that all reasonable attempts to notify me at _____ (phone number) are unsuccessful, I hereby authorize the Department to consent to any emergency medical or surgical treatment, which may be necessary. I understand that I will be responsible to pay the costs of my child's medical care if I am financially able to do so.

4. My child/ren are covered by the following hospital/medical and dental insurance:

Insurance Company

Policy #:

☐ **Part D: Emergency Protective Services and Notification to Parent (CFS-011)**

PROTECTION PLAN AGREEMENT:

I have discussed the attached Protection Plan and the consequences of non-compliance with the caregiver and all those who are responsible for carrying out the plan. I have their agreement to abide by the terms and the conditions of the plan.

By Child Protection Specialist _____

Date _____ Phone _____

Supervisor's Name and Phone _____

I/we have discussed the Protection Plan with the worker. We understand its contents and that it is voluntary, and we agree to abide by the terms and conditions of the plan. If something happens which prevents us from carrying out the plan, we will immediately notify the worker. If the worker is unavailable, we will notify the supervisor. We understand that failure to agree to the plan or carry out the plan may result in a reassessment of my home and possible protective custody and/or referral to the County Attorney's office and a request for a court order sanctioning the emergency removal of my child(ren) from my home if this has not already occurred. I will then have the opportunity to plead my case in court.

I/we have been advised that I may have a support person present during any in-person meeting with a social worker concerning the use of emergency protective services or an out-of-home Protection Plan. I understand that reasonable accommodation must be made in scheduling an in-person meeting with the social worker with regards to placement of child(ren) and use of emergency protective services.

Parent/Caregiver _____ Date _____

Parent/Caregiver _____ Date _____

Safety Resource _____ Date _____

Safety Resource _____ Date _____

Safety Resource _____ Date _____

Child Protection Specialist _____ Date _____

Supervisor Approval:

Date Supervisor gave verbal approval by phone _____ Time _____

Date Supervisor approved written plan _____ Time _____

FOR ICWA PLANS ONLY:

COURT APPROVAL:

Signed and approved by the Hon. _____, Judge of the _____ Judicial District Court,

_____ County, State of Montana, on this _____ day of _____, 20__.